Care Management System
System Description Sub-Committee
01/22/2006

01/23/06 Edits by BT

I. ROLES OF THE STATE HOSPITAL FUNCTION AS OF JANUARY, 2006

1) Role #1: Conduct Emergency Examinations (EEs) (civil)

a) No room at Designated Hospitals (DHs)

i) The general operating principle for all psychiatric hospitalizations in Vermont is admission to the least restricted environment. It is the job of the referring qualified mental health professional (QMHP) to contact all of the DHs for possible admission, accepting that the DHs are less restrictive than the Vermont State Hospital (VSH).

ii) In cases when all five DHs are full, patients are admitted to VSH. When practical, every attempt is made to transfer such patients to the DH serving the catchment from which the patient is referred as soon as a bed becomes available.

b) Too acute for DHs

i) Normally, this is not to say that the patient is too acutely ill for treatment, but that the current treatment milieu would not tolerate the referred patient.

(1) For example, a unit populated by a number of patients experiencing psychotic exacerbations may potentially destabilize if an additional provocative patient is admitted.

(2) Or, staffing issues may prevent the treatment team from adequately caring for the referred patient.

(3) Another example is the potential to refuse admission out of concern for a number of fragile (elderly, impressionable) patients and the risk of exposure to the referred patient.

c) Prominent history of violence

i) A select few patients who are well known to VSH and to have been significantly violent in the past are often referred to VSH immediately. Nevertheless, most patients are admitted to a DH first.

(1) In situations when the violence history is remote, and the patient's current presentation is characterized by less risk of violence, they are accepted by a DH.

(2) However, a common reason for VSH referral is a recent development of violence immediately prior to or during the screening. If, after good faith efforts to treat elements of the patient's illness contributing to the violence fail, transfers to VSH may be appropriate.

d) Unlikely to accept treatment (medication in particular)

i) This is a trend that has seemed to have slowed recently. Mostly, these patients are well known to a DH, and the referring institution is concerned about repeating a pattern of lengthy admissions with little progress because of treatment refusal.

(1) Further, the pattern may consist of eventual transfers to VSH to pursue involuntary treatment which do eventually lead to stabilization and a realized, appropriate, disposition.

(2) Or, the DH representative may be concerned about the realities of being unable to "actively treat" an individual who is compelled to stay but not willing, for example, to take medication.

e) Patient unable to pay for treatment

i) Although the frequency of these kinds of refusals seems to ebb and flow, DHs have refused patients on EEs because of their inability to pay for treatment.

f) Warrants that result because of unavailability of psychiatrists in the community

i) Again, it is incumbent upon the system to ensure that patients are admitted to the least restrictive environment; however, judges can order patients who refuse to be transported for an examination by a psychiatrist to either a DH or to VSH.

(1) In some situations, patients travel a shorter distance if "warranted" to VSH then they would if transported to a DH. Depending on clinical circumstances it may be appropriate to admit the patience to VSH if the VSH physician places the patient in an emergency examination.

(2) Or, it may be more appropriate to make a referral to a DH.

g) Emergency Examinations certified by a non-psychiatrist when it no psychiatrist is available in the community

i) Similar to the situation when the patient is admitted under a warrant, a patient is occasionally screened by a QMHP and, because no psychiatrist is available, he or she is presented to a nonpsychiatricly trained physician (commonly a physician practicing emergency medicine) who is designated by the Commissioner to complete the first certification. In this situation, a patient must be admitted to VSH in order to ensure that the second certification is completed by a psychiatrist.

2) **Role #2: Provide Ongoing Treatment (Civil)**
   a) **Help maintain the Designated Hospital (DH) role of acute stabilization**
      i) Too Acute for DHs.
         (1) This is analogous to the situation described in the EE category, with the distinction that the acuity develops over the course of the admission.
         (2) A good faith effort is made to treat the patient, and the patient's symptoms (usually behavioral) become too difficult or dangerous to treat.
      ii) Prominent history of violence
         (1) Again, this is analogous to the situation described in the EE category.
         (2) However, the patient is either admitted with the treatment team aware of the violence history with a heightened awareness of the possibility of developing violence, or the patient becomes violent acutely.
      iii) *Requires application for commitment.*
         (1) Certain patients admitted to DHs require treatment beyond the initial 72 hours of the EE. In some situations the application is made for commitment and the patient is transferred to VSH.
         (2) In other situations the patient is kept at the DH until the court commits the patient to VSH.
      iv) *Requires court-ordered involuntary medications.*
         (1) *This is a further extension of iii) above.*
            (a) The treatment team at the DH is determines that the patient may need involuntary treatment. In order to affect this, an application for commitment is made. At some appropriate point the patient is transferred to VSH.
      v) Treatment resistant/refractory with sustained prominent symptoms and/or low level of functioning.
         (1) Complicated medical problems*
      vi) Aftercare placement issues.
         (1) High ricidivator/treatment nonadherent
            (a) Programs are reluctant to take some of our patients because of a perception that failure and readmission are inevitable. Patterns of nonadherence cultivate this problem, and we currently have several patients who have protracted illnesses and long admissions punctuated by brief periods in other care environments during which they stopped participating in treatment.
         (2) Notorious history, e.g. fire setting

(a) Some patients are well known by potential disposition providers, and may experience administrative resistance to return to a group home, for example, in which the patient has harmed other residents. Also, some of our patients are known to the community at large for certain elements of their past. Even discussing discharge has provoked notable press coverage. In certain cases it has taken years to foster dialogue allowing transition and discharge.

(3) Nursing home placement problems

(a) Patients with severe memory impairment or dementia with some combination of the above problems may not be placed in an appropriate nursing home because of their symptoms. VSH currently has several patients who would otherwise be appropriate for a skilled nursing facility (SNF). Significant barriers (stigma, previous SNF failure and reluctance to provide a second chance) exist making it quite difficult to place these individuals.

3) **Role #3: Court Ordered Evaluation (Forensic)**

a) Most court-ordered hospital evaluations (which now may occur at participating DHs for selected misdemeanants)

i) Court ordered evaluations typically occur at arraignment. The hospital is asked to observe the patient and provide an opinion regarding capacity and competence. Most often, the patient is screened by a QMHP and he or she recommends the patient be transferred to VSH.

b) Danger to self and/or others

c) Public safety risk

*d) Felony charges**

4) **Role #4: Ongoing treatment (Forensic)**

a) As ordered by the court

i) If a patient is found incompetent to stand trial, they may be admitted to VSH for restoration of competency. Charges may be dropped in lieu of treatment at VSH, or the sentence may involve on going treatment at VSH

b) Transfers from corrections

i) Some patients are admitted from corrections when it is clear they are suffering from symptoms of mental illness and it is felt that the corrections environment is not the most appropriate treatment environment.

II. ROLES OF THE DESIGNATED HOSPITALS (DHs) AS OF JANUARY, 2006

1) **Role #1: Emergency Evaluations (Civil) (NB: Beginning in December, 2005 DHs were able to accept misdemeanant forensic patients).**
   a) *Meets criteria for hospitalization*
      i) The current standard of care for inpatient units in Vermont requires illness to the degree that significant risk exists that the most appropriate place for treatment is the hospital. The slightly confusing vernacular for this is "acuity." Although a salient temporal component exists, the extent of the symptoms is most important for determinning necessity.
      ii) Specific considerations may vary, but usually include: suicidal ideation; recent self-harm; an exacerbation of psychotic symptoms; a significant change in baseline mental status; or a decline in functioning that is potentially life threatening.
   b) *Assessed not to be too disruptive for the milieu*
      i) Generally, patients are well suited to the DH milieu if their symptoms are compatible with high patient mobility, frequent patient-to-patient social contact, and safe interaction with patients who are confused or whose judgment is impaired.
      ii) Occasionally, a DH representative will determine that a particular patient's symptoms may pose an unmanageable risk to patients already admitted.
   c) *Likely no prominent history of violence*
      i) Certain historical elements are most concerning: violence against staff or patients during previous admissions; violence leading to significant injury or death; and violence committed showing gross disregard for consequences (such as violence against law enforcement).
   d) Anticipated medication acceptance
      i) Practically, auditing entities (including revenue sources) criticize institutions who admit patients refusing medication to inpatient units.
2) **Role #2: Ongoing Treatment (Civil)**
   a) *Acute Stabilization* (definition)
      i) In general, the medical term acute describes phenomena that begin quickly and require rapid response. Acute problems are contrasted with chronic problems.
      ii) Most commonly, acute stabilization of patients with dual disorders, for example, refers to the management of physical, psychiatric, or drug toxicity crises. These include injury, illness, toxic or withdrawal states, and behavior that is suicidal, violent, impulsive, or psychotic.

iii) Once the symptoms are not longer considered relevant to imminent risk, the patient is often discharged to a different level of care.

b) Meets criteria for hospitalization

i) Please see the first bullet under "Emergency Evaluations (Civil)."

c) Not assessed to be too disruptive to the milieu

i) Please see the second bullet under "Emergency Evaluations (Civil)."

d) Likely no prominent history of violence

i) Please see the third bullet under "Emergency Evaluation (Civil)."

e) Likely not a prominent elopement risk

i) The potential for a patient to elope has significant perceived liability.

f) Medication acceptance, or application for involuntary medication pending

i) Again, in terms of practical considerations, significant scrutiny from various auditing agencies (including revenue sources) places pressure on DH facilities to discharge or not admit patients refusing medication.

g) Treatment responsive with improved level of functioning

i) If the good faith efforts of the patient and the treatment team have made demonstrable improvement in symptoms and activities of daily living, ongoing treatment is possible.

h) *No prominent aftercare placement issues*

i) A major financial consideration for DH facilities is length of stay. Patients become less ~~desirable~~ the longer they stay. Patients who are difficult to discharge create significant problems for the DH, and they scrutinize potential admissions accordingly.

<--This sentence will be reworded

3) Role #3: Court-ordered evaluations (Forensic)

a) Some court-ordered hospital evaluations for selected misdemeanants in December 2005

b) Danger to self and/or others

i) Like any other patient admitted to a DH, a patient would need to meet admission criteria to experience the evaluation at a DH.

c) Not a prominent public safety risk

i) May be defined by the fact that they are not being evaluated after allegedly committing felonious acts.

d) Not a prominent elopement risk

i) As noted above.

III. ROLES FOR THE SUB-ACUTE REHABILITATION PROGRAMS

1) **Dynamic rehabilitative residential environment to promote Recovery**
   a) *24 hour nursing, 3 awake staff at all times Prominent Nursing Presence 24/7/365*
      i) At least one registered nurse on site at all times
      ii) Additional registered nurse or licensed practical nurse (medications, etc.).
   b) *2x8-10 bed facilities*
      i) (Northeast Kingdom and Central VT or Chittenden County?)
   c) *Length of stay 6-24 months*
      i) The expectation is that persons able to use such services will have accomplished acute stabilization, but will have a degree of symptoms requiring significant time and effort to more fully transition into the community.
   d) *Men and women 18 years and older who are in the care and custody of the Commissioner of Health or, who have just been discharged from the Commissioner's care and custody at VSH*
      i) Only the Brattleboro retreat can admit juvenile patients on an involuntary status.
   e) *Provides intensive, multi-disciplinary rehabilitation services, emphasizing skills needed for recovery and community living*
      i) This has been the hardest to define, because it seems that each program will be individually catered for a specific person. The skills needed for community living and recovery could range from interpersonal communication skills, skills to manage crises, skills for healthy living and management of chronic illness, personal hygiene skills, and vocational / occupational skills.

2) **Offers treatment to persons who in the past have exhibited:**
   a) *Refractory response to treatment*
      i) Unfortunately, some rare individuals have symptoms so severe that they do not respond to any intervention. Because of the severity of certain symptoms, they may require a more restrictive treatment setting. However, some patients do not fully respond to treatment, but may experience an improvement of their most dangerous symptoms. They may benefit from a less restrictive environment that still provides significant structure.
   b) *High rates of re-admission*
      i) Some patients have a history of decompensating quickly after discharge, or may have a sharp increase in admissions surrounding an acute exacerbation of symptoms. Providing longer-term care may provide a more appropriate stability in a less restrictive environment.

c) History of numerous hospitalizations/lengthy hospitalizations

i) Again, some patients are known to destabilize or have a recurrence of symptoms after discharge from VSH. A transitional setting may help to alleviate the need for treatment in the setting designed for the acutely ill.

3) **Intended to be able to consistently reduce the average daily census and average length of stay at the current Vermont State Hospital.**

a) Sub acute rehab units are 24 hour residential units, community based intended to assist persons to transistion out of more restrictive treatment settings, ie VSH

b) They are intended for patients who agree to treatment in that setting

i) An expectation exists that one would make an active decision to be treated at the specific program.

c) Able to take patients under an order of non-hospitalization (ONH)

i) Patients at VSH could be discharged under an ONH—providing the opportunity to revisit the need to treatment at VSH after a hearing.

d) There would be the capacity to handle agitated patients by virtue of providing one to one or possibly two to one staff monitoring as well as affording time in a quiet room

i) Since seclusion is a clear element of a restrictive environment, it is important to delineate the SAR facilities as less restrictive. However, the nature of certain symptoms may require the ability to gently intervene with strategies that minimize stimulation and keep the locus of control within the patient.

e) Short term manual restraint would be available, but mechanical restraints and emergency involuntary medications would not

i) Rarely, but safely, staff will be able to place hands on acutely agitated patients when all other methods have failed in order to prevent harm.

f) Containment would largely be provided by staff surveillance. Although exterior doors would have the capacity to lock if deemed clinically necessary

i) Limited situations may require temporarily locked doors; a program may determine that it is safest to lock doors at night, or if a patient demonstrates impaired judgment and impulsivity.

g) The expectation would be that a covering psychiatrist could be present within one-hour of notification

i) Most issues, even after hours, would be routine and could be solved with a telephone conversation with the covering physician.

ii) However, for more urgent situations, a psychiatrist would be able to make face-to-face evaluations of patients 24 hours a day, seven days a week, 365 days a year.

h) *The expectation is that a resident at the SAR would not use alcohol or illicit substances (i.e. the SAR is a "dry", not "damp" or "wet" program)*

4) **For More Discussion:**

a) *Return to VSH through judicious use of "stipulated EE" or continued use of "PPV"*

i) A stipulated EE is an agreement with a person that when he or she meets certain stipulated criteria, he or she can be placed on an EE and admitted. A PPV (Pre-placement Visit) is an arrangement with VSH whereby a person is transferred to another facility but remains admitted to VSH. If needed, the person can be immediately returned to VSH.

b) *Or have these programs be part of a system of care under the hospital with contractual treatment agreements.*

i) Incorporating each facility into the VSH brand would be helpful in integrating patients. It would assuage any concern regarding the ability to appropriately place patients at the acute or sub acute facility (from one facility to the other) depending on clinical need.

c) *Treat Involuntary Patients.*

i) Currently on DHs and VSH treat involuntary patients.

d) *Sub-acute rehab units would ideally be designated through ACT 114 so that persons could continue to benefit from court-ordered non-emergency oral involuntary medications*

i) Currently, persons in Vermont only receive involuntary oral medications at VSH. Having the ability to transition a patient to a less-restrictive environment while following the court's order would benefit many patients.

IV. ROLES OF THE SECURE RESIDENTIAL PROGRAM

1) 3-6 beds
2) LOS 1-5 years
   a) Court-ordered/legally managed
      i) Psychiatrically stable (not necessarily symptom-free).
         (1) Again, acute stabilization has been accomplished, and the person is experiencing symptoms that might otherwise be treated in other less acute environments.
   b) Persons who pose risk to public safety secondary to:
      i) TBI

ii) Dementias

iii) Treatment refractory

V. ROLES OF THE SHELTER + CARE PROGRAMS

1) The Shelter Plus Care Program provides rental assistance for hard-to-serve homeless persons with disabilities in connection with supportive services funded from sources outside the program.
   a) The program allows for a variety of housing choices, and a range of supportive services funded by other sources, in response to the needs of the hard-to-reach homeless population with disabilities
2) Shelter Plus Care (S+C) is a program designed to provide housing and supportive services on a long-term basis for homeless persons with disabilities
   a) Serious mental illness
   b) Chronic problems with alcohol and/or drugs
   c) Acquired immunodeficiency syndrome (AIDS) or related diseases
3) Also designed to help the families of these individuals
4) Targeted to help those living in places not intended for human habitation
   a) Streets
   b) Emergency shelters.
5) Program grants are used for the provision of rental assistance payments through four components:
   a) Tenant-based Rental Assistance (TRA)
   b) Sponsor-based Rental Assistance (SRA)
   c) Project-based Rental Assistance with (PRAW) or without (PRA) rehabilitation Section 8 Moderate Rehabilitation
   d) Program for Single Room Occupancy (SRO) Dwellings.
6) The supportive services may be funded by other Federal, State, or local sources, as well as private sources.

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VI. ROLES OF THE COMMUNITY CARE HOMES

1) Level III Residential Care Homes – NO ACCS (State L/A Code Z)

a) DAD certifies Level III Residential Care Homes with no ACCS

b) This type of Level III home is what was formerly known as Custodial Care: Licensed Community Care Homes, Level III, State L/A category F.

c) Residents in such homes were eligible for the Federally administered State L/A category F prior to July 1999.

d) Some of these Level III residential care homes still exist and residents of them may be eligible for a State administered State supplementary payment at the level of payment for the former State L/A category F.

e) PATH is responsible for State supplementary payments for residents in these homes.

f) Many of the homes that were in this category when SSA administered the State supplement have, or will, convert their license so that their residents are eligible for category

   i) If they do not appear on the State L/A category C list on BOSNet, they have not yet done so.

Draft needs much reworking